NATURE FUL CONNECTIONS
FOREST THERAPY WITH JULIA B

Health Questionnaire

Date: _____

Full Name: _____ DOB: _____

Address: _____

email: _____

Phone: _____ Alt Phone:_____

Primary Care Physician: _____

Physician Phone number: _____ _____

Medical Insurer _____ Group|Policy No_____

Emergency Contact: _____

Relationship: _____

Phone: _____ Alt Phone:_____

Does your doctor know you are going to participate in this program: ❑ Yes ❑ No

Does your emergency contact person know you will participate: ❑ Yes ❑ No

Do you wear a Medic-Alert Tag or any other marker of a medical problem? ❑ Yes ❑ No
If yes, please describe:

Do you have allergic or anaphylactic reactions to any insults, such as environmental substances, foods, drugs, insect bites or stings? ❑ Yes ❑ No
If yes, please describe, and let us know if you carry an Epi pen or other fast-acting medication:

If you walked on the level for a mile at an average pace would you get out of breath, have pains in the chest, develop muscle fatigue or have pains in your legs? ❑ Yes ❑ No
Describe your degree of fitness in your own words:

Do you have any other health-related disease, condition, or concern that program guides should be aware of? ❑ Yes ❑ No
If yes, please describe:

Signature

This information is accurate and complete. I agree to communicate fully with program instructors and Guides any health concerns that may arise. I give my permission to staff of the Association of Nature and Forest Therapy Guides to seek emergency medical diagnosis or treatment for me in the event that I am unconscious or unable to make my own decisions. I understand that should I need medical care for any reason while participating in this program the role of Guides will be limited to emergency first-aid and either transportation to the nearest medical facility, or contacting such a facility to arrange emergency transport.

SIGNATURE: _____